

Wellness Update

Patient name






Date of birth

Today's date


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How often do you have these symptoms?

(Please check one box in the Severity section and Frequency section)

		SEVERITY			FREQUENCY		
		Mild	Moderate	Severe	Never or Occasionally	Seasonal	Most of the Year/Daily
	Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stuffy Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Frequent Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chronic/Seasonal Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus Pressure/Sinus Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dry, Red, or Itchy Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Consistent Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy Mouth / Throat Clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Restless Sleep / Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Daytime Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often do you use the following?

		Never or Occasionally	Seasonal	Most of the Year/Daily
			Over-the-Counter Antihistamine (Allegra®, Claritin®, Zyrtec®, Benadryl®, etc)	<input checked="" type="checkbox"/>
Over-the-Counter Nasal Spray	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Prescribed Allergy Medication/Spray	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Neti Pot	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Patient/Guardian signature

Date

Patient phone

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FOR CAT/CAS USE ONLY

Date of Last Physical Exam: _____

Order Allergy Test: Yes No

Provider Signature: _____ Date: _____

